Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

In the Matter of	**)**	
	)	
Rural Health Care Support Mechanism	**)**	WC Docket No. 02-60

REPLY COMMENTS OF THE HEALTH INFORMATION EXCHANGE OF MONTANA, INC.

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September 23, 2010

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SUMMARY

Although there was broad agreement by commenters that dramatic change is needed for the RHC Program to reach the over 60% of eligible entities who are not participating, some commenters expressed concern that the Commission's proposed Health Infrastructure Program ("HIP") would repeat the mistakes of the Commission's Pilot Program for health infrastructure funding. HIEM agrees the Commission must be careful not to introduce burdensome new requirements to the HIP. Nevertheless, the HIP, like the Pilot Program will foster the development of effective and sustainable state and regional network organizations. These organizations are key to mitigating administrative burdens and increasing participation by individual health care providers. Increased participation will be the ultimate measure of the RHC Program's success.

HIEM supports the following:

- Rural health providers should continue to have the option to construct and sustain their own broadband facilities which is essential to ensuring cost effective rural broadband development.
- The record clearly supports the continued need for dedicated rural health infrastructure funding.
- Continuing current policies on excess capacity will ensure health care provider-controlled networks will not be silos and will benefit rural communities.
- Health care providers are capable of contracting to construct and maintain networks when doing so is more cost effective than other available options.
- RHC Program support should not be based on compliance with Health and Human Services' "meaningful use" criteria.
- The Health Infrastructure Program should allow in-kind contributions.
- Minimum bandwidth requirements will penalize those program participants most in need of Rural Health Care Program support.
- Timely administrative decisions are critical to infrastructure development projects and the Commission can take steps to reduce difficulties in this area.

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The Health Information Exchange of Montana, Inc. ("HIEM"), by its attorneys, hereby submits its reply comments in response to the Federal Communications Commission's ("FCC" or "Commission") Notice of Proposed Rulemaking, FCC 10-125, released July 15, 2010 ("NPRM"), in the above captioned proceeding.

INTRODUCTION

There is little if any disagreement with the Commission's conclusion that the "Rural Health Care Program as currently structured . . . is not meeting the country's needs."[1] No commenter challenged, for example, the Commission's conclusion that less than one-third of potentially eligible entities participate in the RHC Program.[2] This unacceptably low participation rate – over 10 years into the program's life – speaks louder than any performance

[1] *See* Federal Communications Commission, *Connecting America: The National Broadband Plan* at 213 (rel. Mar. 16, 2010) ("NBP" or "National Broadband Plan"); NPRM at ¶ 9 ("Historically, the Rural Health Care [("RHC")] Support Mechanism has not been fully utilized.").

[2] *See* NPRM at ¶ 9 (noting about 3000 participants out of an estimated 9800 eligible). The NBP concluded "[l]ess than 25% of the approximately 11,000 eligible institutions are participating in the program[.]" *See National Broadband Plan* at 214. Moreover, the NBP noted its methodology likely underestimated the number of eligible participants because it excluded community mental health centers, postsecondary medical education, or state prisons. *See id.* at 221, fn. 103.

[3] While "low" annual disbursement levels relative to a $400 million program cap have limited usefulness in

[2] *See* NPRM at ¶ 9 (noting about 3000 participants out of an estimated 9800 eligible). The NBP concluded "[l]ess than 25% of the approximately 11,000 eligible institutions are participating in the program[.]" *See National Broadband Plan* at 214. Moreover, the NBP noted its methodology likely underestimated the number of eligible participants because it excluded community mental health centers, postsecondary medical education, or state prisons. *See id.* at 221, fn. 103.

measure about whether the RHC Program is meeting the needs of rural America.[3] Thus, it is not surprising commenters are nearly unanimous in supporting bold Commission action to realize the full potential of the RHC Program.

In considering the path forward, HIEM again urges the Commission not to abandon innovative policies that have proven successful and, with the Commission's clear support going forward, can be even more so. Specifically, the Commission should continue to support non-profit health care organizations seeking to establish or upgrade regional and statewide broadband health networks that will benefit rural communities. In addition, the right policies regarding installation of excess network capacity will enable these networks to be a vital part of their regional broadband "ecosystem." Proper use of excess network capacity can increase the availability of cost effective bandwidth available to serve the broader community – from rural schools, libraries and other public or non-profit organizations seeking affordable connectivity, to rural carriers seeking to extend their networks to reach additional end-users.

Just as important as regional and statewide networks being created as a result of Commission actions are the organizations emerging to operate them. Organizations such as HIEM, Rural Nebraska Healthcare Network ("RNHN"), Oregon Health Network ("OHN"), California Telehealth Network ("CTN"), Colorado Health Care Connections ("CHCC"), Palmetto State Providers Network ("PSPN") and New England Telehealth Consortium ("NETC") (just to name a few that commented in this proceeding) will continue to play positive roles in their states and communities promoting and supporting adoption of Health IT for many

[3] While "low" annual disbursement levels relative to a $400 million program cap have limited usefulness in assessing the success of the RHC Program, low rates of participation by potentially eligible entities, particularly after such a long period of time, suggest either fundamental flaws in program design, lack of adequate outreach and training, poor program administration, or some combination thereof.

years to come.[4] Fostering the creation and success of such organizations should continue to be foremost in the Commission's thinking as it charts a way forward.

I. ALLOWING RURAL HEALTH PROVIDERS THE OPTION TO CONSTRUCT AND SUSTAIN THEIR OWN BROADBAND FACILITIES WILL HELP ENSURE COST EFFECTIVE RURAL BROADBAND UTILIZATION

A. Continuing Unmet Demand for Federal Broadband Funding and the Lack of Multi-Provider Competitive Bidding Demonstrates the Need for a Rural Health Infrastructure Program

The Commission's proposed $100 million annual commitment to health care infrastructure funding through the Health Infrastructure Program ("HIP") is far from unneeded or insignificant as some commenters suggested.[5] Rather, HIEM agrees with Geisinger Health System that overwhelming and unmet demand for federal broadband funding available through the Commerce Department's National Telecommunications and Information Administration ("NTIA") and Department of Agriculture's Rural Utilities Service ("RUS") illustrates that the $7.2 billion available as part of the American Recovery and Reinvestment Act has not come close to meeting the demand for broadband in rural areas.[6] Indeed, for the $4 billion available in the first round, these programs received thousands of applications requesting $28 billion in broadband infrastructure funding – seven times more funding than was available.[7]

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[4] *See* OHN Comments at 8-9 (noting "RHCPP organization such as OHN have earned trusted partnerships in their communities" and have the "relationships that are needed to build out their provider networks as components of a larger national health care network."); *see also* Modern Technologies Group, et al. Comments at 3, 8 ("health care providers may require the expertise of [consortium leaders] in building robust, secure, and cost-effective infrastructure").

[5] *See, e.g.,* American Telemedicine Association ("ATA") Comments at 3-4 (arguing that $100 million annual HIP funding is "small and insignificant" compared to the $7.2 billion federal Broadband USA program).

[6] *See* Geisinger Comments at 6-8 (urging the Commission to, among other things, adopt a $200 million annual HIP funding cap).

[7] *See* Press Release, NTIA, Commerce and Agriculture Announce Strong Demand for First Round of Funding to Bring Broadband, Jobs to More Americans, August 27, 2009, http://www.ntia.doc.gov/press/2009/BTOP_BIP_090827.html (September 23, 2010, 12:02 EST). For the $2.7 billion available in the second round, $11 billion in funding requests were received. *See* Press Release, NTIA,

Moreover, the Commission has already recognized the existence of a connectivity gap affecting rural health care providers. As Geisinger explained in its comments:

> [T]he National Broadband Plan [noted] 29% of federally funded rural health care clinics lack access to even mass-market broadband. The [NBP] found that a mass-market broadband connectivity gap exists for an estimated 3,600 health care providers, 2,500 of which are located in "rural" areas. This astonishing connectivity divide essentially denies rural communities the benefits of advanced telemedicine. Further, larger health care providers require dedicated broadband solutions, which deliver the greater speeds and reliability needed to utilize advanced health care technologies.[8]

Finally, in comments filed by the Department of Health and Human Services ("HHS") (at the Commission's invitation), HHS noted the likelihood of "heightened" demand for FCC rural infrastructure funding between now and 2017 as providers – especially rural providers – seek to qualify for incentive payments available from HHS to those able to meet benchmarks for the deployment of electronic health records.[9] The record establishing unmet demand for rural broadband infrastructure and a substantial connectivity gap for rural health care providers is thus clear.[10]

Further evidence of the need for new facilities can be found in the continued prevalence of single-provider bidding in the RHC Program. RHC Program rules require participants to post requests for services for at least 28 days, and then to select the most cost effective service among

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Commerce Announces Continued Demand For Funding To Bring Broadband To More Americans, April 7, 2010, http://www.ntia.doc.gov/press/2010/BTOP_Round2Applications_04072010.html (September 23, 2010, 12:04 EST).

[8] Geisinger Comments at 7 (footnotes omitted) (citing NBP at 211-13).

[9] HHS Comments at 4-5.

[10] *See also* Federal Communications Commission, Health Care Broadband in America: OBI Technical Paper No. 5 at 9-11 (rel. August 2010). While Dedicated Internet Access ("DIA") may be "available" everywhere – via satellite connection for example – the high cost of such solutions makes them effectively unavailable. *See id.* at 10; *see also* Iowa Health System Comments at 2-3 ("continued focus on subsidizing existing service does not move healthcare where it needs to be."); *cf.* Inquiry Concerning the Deployment of Advanced Telecommunications Capability to All Americans in a Reasonable and Timely Fashion, and Possible Steps to Accelerate Such Deployment Pursuant to Section 706 of the Telecommunications Act of 1996, Amended by the Broadband Data Improvement Act, GN Docket Nos. 09-137, 09-51, Report, FCC 10-129, ¶ 2 (rel. July 20, 2010) (concluding for the first time broadband deployment has not been reasonable and timely for all Americans).

competing offers.[11] However, the number of program participants receiving only one offer for service during the 28-day posting period is apparently common enough that Virginia Telehealth Network ("VTN") proposes eliminating competitive bidding in such cases in order to "streamline" the application process.[12]

The purpose of the Commission's competitive bidding requirement is to ensure the universal service funds are "used wisely and efficiently" by ensuring "rural health care providers are aware of cost effective [service] alternatives."[13] When there are no cost effective alternatives, that purpose cannot be fully realized. In seeking opportunities for streamlining the RHC application process, VTN identifies a critical reason why the HIP program is essential: the continuing absence of alternative service providers for many rural health care providers.[14]

Finally, the need for physical redundancy is another reason for direct health infrastructure funding. Many commenters addressed this critical need.[15] HIEM agrees physical redundancy is important to ensuring rural health networks are hardened against disasters (whether natural or man-made) and therefore the construction of additional facilities in rural areas can promote physical redundancy. Moreover, because service providers are not required to disclose the physical location of their facilities to end-users, there is no reliable method for health care providers to obtain assurance that connections from different service providers do not traverse

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[11] *See* 47 C.F.R. § 54.603.

[12] *See* VTN Comments at 34.

[13] *See* Federal-State Joint Board on Universal Service, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776, ¶¶ 686-89 (1997) ("Universal Service First Report and Order").

[14] For the Commission to even consider reversing course on the need for direct health infrastructure funding, at a minimum it would be necessary to establish for the record the prevalence of single-bid situations in the RHC Program. Only then could the benefits of the HIP program and the potential cost to rural health care providers and the RHC Program of failing to pursue the HIP program be fully considered.

[15] *See, e.g.*, Geisinger Comments at 10-11 (noting critical health applications that require high performance and redundancy); *but see* Illinois Rural HealthNet ("IRHN") Comments at 5 ("While physical redundancy is strongly desirable, the reality is full, diverse redundancy to all locations may be cost prohibitive.")

some of the same physical facilities at some critical juncture in the network. Particularly in remote areas with few service providers, having control over their own network may be the only truly reliable method for health care providers to have full assurance regarding physical redundancy. Whether the Commission concludes physical redundancy is required or simply desirable, the HIP program is essential to ensuring cost effective physical redundancy.

B. The Commission Should Continue Current Policies which Ensure Health Care Provider-Controlled Networks Are a Vital Part of the Rural Broadband Ecosystem

Two concerns were raised by telecom operators. First, deploying dedicated health broadband networks could somehow undermine the development of commercial networks that would otherwise serve the needs of the non-health care community.[16] By removing potential anchor institutions such as large clinics and hospitals as potential customers for commercial networks, some argued dedicated health networks would in fact decrease the availability of broadband to the larger rural community.[17] Second, that rules permitting the leasing of excess capacity violate the Communications Act.[18]

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[16] In expressing this concern, commenters Montana Telecommunications Association ("MTA") and Montana Independent Telecommunications Systems ("MITS") went so far as to make contested factual claims concerning the HIEM project. *See* MTA Comments at 11-13; MITS Comments at 5-6. The HIEM project has at all times followed Commission rules for the receipt of funding through the RHC Pilot Program, including posting requests for proposals ("RFPs") for the required 28-day period and selecting the most cost-effective bid for services. All broadband service providers in Montana were eligible and encouraged to bid. Regarding MITS' claim that health care clinics in the HIEM network already have fiber connections provided by MITS member InterBel Telephone Cooperative Inc. ("InterBel"), HIEM reiterates its hope that InterBel will submit a bid to provide services for those locations when HIEM posts its RFP for that segment of its network. *See* Letter from Kip Smith, Executive Director, HIEM, to Randy Wilson, General Manager, InterBel, September 2, 2010 (on file with HIEM and available upon request).

[17] *See, e.g.*, General Communications Inc. Comments at 13-14; National Telecommunications Cooperative Association ("NTCA") Comments at 5-6; *see also* VTN Comments at 37; OHN Comments at 4-5 (although noting "the right to construct new dedicated facilities to rural communities is a necessary backup option in case telecommunications service providers do not provide satisfactory responses to requests for service proposals.").

[18] *See* MTA Comments at 9-11; *see also* ATA Comments at 5.

With respect to the first concern, expressed by commercial operators who have deployed fiber subsidized by the universal service support mechanism, they appear to be saying that leasing facilities from telephone companies is the only acceptable way to participate in this program. That cannot be the case, unless the FCC is prepared to discontinue the competitive bidding process for both the Rural Health Care Program and the related Schools and Libraries Program. As HIEM has previously stated, competitive bidding is essential to ensuring that Rural Health Care program dollars are used efficiently and that vendors put forth their best possible offer.

If a program vendor has fiber deployed in an area where a program participant needs capacity, then the vendor should have no trouble submitting a bid that is lower than the cost of building new facilities. If a carrier can't do that, when its existing plant was built with the help of subsidies, then something is amiss.

Alternatively, if there is no fiber in an area where a program participant needs capacity, then there's nothing in the Communications Act requiring a program participant to select a bid from any company if a more cost-effective alternative exists. In fact, it would amount to misuse of government funds for program participants to select a higher-cost bid.

By requiring program participants to select the most cost-effective option, and by allowing program participants to construct dedicated network facilities, the Commission has forced telecom carriers to submit competitive bids that do not reflect or anticipate market power. Moreover, HIEM understands that in many areas of the country, there are both lit and dark fiber assets held by parties who are not traditional telecom carriers, such as gas transmission

companies or railroads.[19] In HIEM's case, the federal funds expended on its fiber link across the Continental Divide using the assistance of the Burlington Northern Railroad were a small fraction of what they would have been otherwise.

With respect to the second concern, using excess capacity to sustain networks, as HIEM and other commenters noted,[20] the RHCPP allows dedicated health networks funded by RHC funds to construct excess capacity available for non-health care use and to lease that capacity out, provided all proceeds are used to sustain the network.[21] On this point, HIEM supports Illinois Rural HealtNet's proposal to require "any excess capacity built into a [HIP-funded] health care network [to be] made available on a wholesale basis to users and . . . broadband service providers."[22] The point is health care providers have no interest in becoming carriers or in otherwise competing against commercial providers in the provision of end-user services.[23] Rather, HIEM believes HIP-funded excess capacity can provide opportunities for community institutions to access affordable broadband, and for commercial telephone operators to extend

[19] HIEM notes with approval today's decision to allow dark fiber assets to be used in the Schools and Libraries program, as it has the potential to increase efficiency, utilization, and options for program participants. As the Chairman said in his separate statement, "The goal is – and I believe the result will be - more bang for the E-rate buck; faster speeds and lower costs. This is a major step toward the Broadband Plan's goal of affordable access to super high speed broadband at anchor institutions in every community across the country." *See* Statement of Chairman Julius Genakowski, *Schools and Libraries Universal Service Support Mechanism*, CC Docket No. 02-6, *A National Broadband Plan for Our Future*, GN Docket No. 09-51 (September 23, 2010).

[20] *See* HIEM Comments at 4-16; Rural Nebraska Healthcare Network ("RNHN") at 12-13; IRHN Comments at 2, 11-13.

[21] *See* RHCPP Excess Bandwidth and Excess Capacity Scenarios, scenarios 3 and 8.

[22] *See* IRHN Comments at 11-12.

[23] ATA argues the FCC's excess capacity policies are equivalent to using federal funds to overbuild a hospital and then using the extra space for a hotel. *See* ATA Comments at 5. More accurate analogies would be to consider the appropriate use of the crawl space between hospital floors or the disposition of revenue from excess power sold back to the power company from federally subsidized solar panels installed on the hospital's roof.

their own networks and thereby provide more affordable broadband services to potential end-user customers in rural communities.[24]

Finally, HIEM reiterates its initial comments supporting the Commission's conclusion that the leasing of excess capacity by eligible health care providers to third parties does not violate the resale restrictions contained in the Telecommunications Act.[25] Those restrictions apply when "services or network capacity [are] provided to" a health care provider by a carrier at a discounted rate. In an infrastructure build, the health care provider leases nothing from a carrier and thus cannot be said to be "reselling" anything.[26]

Moreover, the network facilities funded with universal service support are being used solely for program purposes. By definition, excess capacity is built with private funds, not program funds. Accordingly, even if one accepts that such capacity is being "resold," the assets being resold were not "provided to" the health care provider – in fact they were paid for by the health care provider. The FCC has been very careful in requiring program participants to use either incremental or fair share allocations to ensure that program funds do not purchase facilities that are resold.

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[24] RNHN suggests the Commission could tailor excess capacity policies to indirectly address the connectivity gap faced by for-profit health providers who are frequently the sole providers of health care in remote or impoverished areas. *See* RNHN Comments at 12-13 (Commission should allow projects to use excess capacity "for any lawful purpose" provided revenue used solely to sustain the network); *see also* National Broadband Plan at 214 (noting need to support safety-net health care providers such as for-profit physician offices; "in rural areas alone, for-profit eligibility restrictions exclude more than 70% of the 38,000 health care providers").

[25] *See* HIEM Comments at 4-10. 47 U.S.C. Section 254(h)(3) provides: "Telecommunications services and network capacity provided to a public institutional telecommunications user under this subsection may not be sold, resold, or otherwise transferred by such user in consideration for money or any other thing of value."

[26] Notwithstanding, with the Commission's excess capacity policies having been in place since at least 2008, the time for challenging their legality is long past.

C. Health Care Providers are Capable of Selecting the Most Cost Effective Networking Option and If Needed Contracting to Construct and Maintain a Network

In criticizing the Commission's HIP proposal specifically and the RHC Program generally, some commenters focused on regulatory complexity and administrative burdens – essentially arguing that health care provider organization lack the time or expertise to navigate the HIP process proposed by the FCC. While HIEM agrees the infrastructure funding process under the RHCPP proved unexpectedly burdensome, scrapping the idea of infrastructure funding as some commenters proposed[27] would be a disproportionate reaction to these shortcomings.

As HIEM previously commented, the Commission must be careful not to create a HIP process that is insurmountable.[28] For example, a HIP application process that shifts the burden of proof to applicants to demonstrate the need for new facilities – such as the 60-day "comment window" process proposed by the rural carrier representative, NTCA,[29] could easily shut down the pipeline for promising HIP projects. Other commenters expressed similar concerns.[30] For example, the American Hospital Association ("AHA"), in urging the Commission "to use a lighter touch" in fashioning application and eligibility requirements,[31] explained:

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[27] *See, e.g.,* ATA Comments at 1-5; National Rural Health Association ("NRHA") Comments at 2, 4-5; *cf.* VTN Comments at 13-14, 36-40 (proposing deferred implementation of the HIP pending further inquiry).

[28] *See* HIEM Comments at 10-16.

[29] *See* NTCA Comments at 4-6.

[30] *See, e.g.,* Nebraska Statewide Telehealth Network ("NSTN") Comments at 2 ("Pre-application verification of no or insufficient broadband accessibility puts an undue burden on the applicant and requiring a six-month posting period to prove that no telecommunications carrier can provide requested services creates an application process that is overly lengthy and does not help networks move forward in serving our communities."); Oregon Association of Hospitals and Health Systems ("OAHHS") Comments at 1 (Commission should "avoid complex application processes"); Internet2 Ad Hoc Health Group ("Internet2") Comments at 8-9 (proposed need determination process "places a significant burden on the health care provider"); Iowa Health System Comments at 2 (recommending elimination of "excess administrative burdens such as requiring proof that broadband services are insufficient."); *cf.* IRHN Comments at 5-7 ("The expenditure of significant time and effort to prove or disprove whether someone has fiber buried in the ground is meaningless if access to the fiber is not made available at an affordable cost.").

[31] AHA Comments at 3-4

> [T]he existence of commercially available facilities in an area may not be determinative of their adequacy for health care purposes, and thus of eligibility for funding under the [HIP]. Health care providers choosing to undertake the construction of facilities under the [HIP] will have given great weight to any existing broadband alternatives available. Even where some facilities do exist, they may be insufficient for health care purposes, including factors of reliability and quality of services from existing providers.
>
> [A]dding the substantial burdens related to the showing of availability in the application process may not improve the process, but only discourage eligible applicants from requesting funding. [32]

In addition, HIEM reiterates there is nothing complex about contracting to construct a network. It is no different than contracting to construct a new wing to a hospital – something surely not outside of the core competency of any health organization of significant size.

One area where the Commission has substantially improved the HIP process over the RHCPP is in having USAC rather than the FCC select successful applicants. This will help avoid situations like the frustrating setbacks described by VTN when, after their RHCPP application had been approved by the FCC, central elements of the project were later found by USAC or the FCC to be ineligible for support.[33] Having USAC perform the HIP application screening and approving initial awards will greatly reduce the potential for unwelcome surprises like those experienced by VTN after their application had initially been approved.[34]

Supporting administrative costs will also go some way to mitigating the types of difficulties related by RHCPP participants such as VTN. Notably, commenters echoed HIEM's

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[32] *Id.* at 4.

[33] *See* VTN Comments at 7-13 (describing unsuccessful efforts to realize the project described in VTN's FCC-approved pilot program application to construct the Virginia Acute Stroke Telehealth ('VAST') Network).

[34] *See also* Washington Rural Health Association ("WRHA") Comments at 3 (pre-award evaluation stage is critical to ensuring HIP project success).

proposal that the Commission include legal expense as one of the types of supported administrative costs.[35] For example, HHS explained:

> Rural health networks may not have in-house counsel and given the complex nature of developing the coalitions needed to successfully advance the kind of projects envisioned in this NPRM, the rural health networks may incur some related legal fees that are purchased on an as-needed retainer basis.[36]

HIEM concurs with this statement and notes that development of coalitions echoes our concern that developing effective, sustainable state and regional network organizations is crucial to increasing participation rates in the RHC Program. HIEM therefore reiterates that legal costs associated with project administration should be considered eligible administrative expenses (and would count toward whatever cap or other limitation the Commission places on the allowable amount of administrative expenses).[37]

Concerns about administrative burdens and health care "core competencies" come down to having effective organizations with resources. Effective and sustainable regional or statewide health network organizations are the key to overcoming potential HIP obstacles. Such organizations can help individual health care providers by handling RHC administrative matters on their behalf. Aggregating the needs and demands of network members is precisely the way forward, not continuing to leave isolated facilities to fend for themselves with USAC and with single-bid "competitive biddings" that cannot be relied upon to consistently produce cost-effective outcomes.

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[35] *See* Broadband Principals Comments at 18 ("It is not realistic to disallow legal costs [because] these projects cannot be done without contracts. These costs, to the extent they are directly related to the project, should be allowed as part of the administrative expense, and the ceiling for administrative expenses should be increased[.]"); RNHN Comments at 8; IRHN Comments at 8; OAHHS Comments at 1; NSTN Comments at 4; Modern Technologies Group, et al. Comments at 16.

[36] *See* HHS Comments at 7.

[37] *See* HIEM Comments at 23-25.

The Commission should recognize that current RHCPP policies that allow networks to lay excess capacity and to raise funds by leasing out that capacity foster the creation of network organizations and help ensure the networks they operate are sustainable. This is what will ultimately increase RHC Program participation, increase rural access to broadband, and drive costs down for all health care providers whether they are directly eligible for RHC benefits or not.

II. ADDITIONAL COMMENTS

A. Commenters Urged the Commission Not To Employ HHS "Meaningful Use" Standards as an RHC Program Performance Measure

Commenters broadly opposed employing "meaningful use" criteria established by the HHS as a performance measure[38] – especially to the extent the Commission considers conditioning future RHC support on health care providers meeting those standards.[39] Notably, HHS, who the Commission specifically invited to submit comments, suggested the Commission not condition RHC support upon achieving meaningful use "because the absence of that support may be the reason for their failure to become meaningful users."[40] HHS offered to participate with the Commission in designing useful performance measures for the RHC Program and HIEM reiterates its support for taking whatever time may be necessary to do so.[41]

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[38] "Meaningful use" criteria are intended to measure the efficient use of Health IT by physicians and hospitals. *See* NPRM at ¶ 142. As the Commission explained, Health IT includes "billing and scheduling systems, e-care, electronic health records ("EHRs") and telehealth and telemedicine." *See id.* at ¶ 2 (citing National Broadband Plan at 200).

[39] *See, e.g.* Rural Wisconsin Health Cooperative Comments at 4-5; CTN Comments at 28-29; VTN Comments at 35; AHA Comments at 9-10; ATA Comments at 16.

[40] *See* HHS Comments at 14-15.

[41] *See* HIEM Comments at 19-21.

B. Commenters Supporting the HIP Broadly Supported Allowing In-Kind Contributions

Comments broadly supported loosening the requirements for project matching funds to allow in-kind contributions.[42] Strong support for allowing in-kind came from HHS who also recommended a very low or no matching requirement in certain cases.[43] Where matching is required HHS suggested the Commission allow applicants to consider as eligible funds "in-kind cost participation broadly defined, such as devoting in-kind [staff] support to the project or operating space or shared use of computer servers and equipment, and that for-profit providers' be allowed, since in rural areas these providers might naturally team up (because of the scarcity of providers there)."[44] HIEM strongly supports this approach.

C. Commenters Expressed Concern that Minimum Bandwidth Requirements Will Penalize the Most Remote and Impoverished Program Participants

Minimum bandwidth requirements in both the HIP and the HBSP were opposed by some commenters on the grounds such requirements risked excluding those participants who could benefit the most from RHC support – that is, those with little resources to afford faster connections or those in the most remote areas where faster connections are the most costly.[45] HIEM continues to share the concerns of commenters who believe minimum bandwidth requirements will hurt those health care providers most in need of support.

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[42] *See, e.g.,* Iowa Health System Comments at 5; Internet2 Comments at 14-15; RNHN Comments at 10-11; NSTN Comments at 4.

[43] *See* HHS Comments at 7-8 (recommended low or no matching requirement for HIP applicants "where a majority of the participating health care providers are in underserved areas, or in high poverty counties; key Federal safety-net providers such as Federally Qualified Health Centers, Rural Health Clinics, Critical Access Hospitals, Medicare Dependent Hospitals, Sole Community Hospitals, and Tribal and/or Federal Indian Health Service sites; or for those providers who are defined as being eligible for meaningful use incentives in HHS' final regulations.").

[44] HHS Comments at 8.

[45] *See* e.g., CTN Comments at 10-11 (supporting a benchmark but not a minimum requirement); HHS Comments at 10. *But see, e.g.,* Iowa Health Systems Comments at 3 (suggesting 1 Gbps as a "more realistic, forward looking target" that would allow multiple video and data streams for more than one use at a time.)

D. The FCC Should Consider Greater Reliance on Self-Certification Subject to Audit to Ease the Administrative Processes for the HIP

Commenters have established a significant record of suggestions for administrative improvements to the HIP process. For example, one Pilot Project commented that in the RHCPP "there is a great deal of lag time, sometimes months, between review and approval of all these processes" and suggested projects be permitted to "self manage[] . . . subject to audit similar to [m]any government funded projects."[46] Another Pilot Project suggested "USAC be granted more flexibility [and be] empowered to make more timely decisions without needing to escalate matters to senior management or going outside of USAC to the FCC for approval. Given strict deadlines, the decision making must be more swift and flexible to get projects up and running."[47]

Financing and building large infrastructure projects requires coordination of numerous time-sensitive deadlines. For example, matching funds can be available for limited time periods[48] and adverse weather creates construction windows that are immovable. Timely decision-making by administrators and policy makers is thus critical for large infrastructure efforts to be successful. To put it more bluntly, receiving no decision or a delayed decision can kill a promising project just as readily as receiving an adverse decision.

There are two ways the Commission can address this issue. The first is to provide clear rules to minimize concerns USAC may have about running afoul of Commission rules prohibiting it from interpreting unclear rules or making policy.[49] This includes providing timely

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[46] *See* University of Hawaii Telecommunications and Information Policy Group Comments at 1-2.

[47] *See* CTN Comments at 32-33.

[48] *See* PSPN Comments at 11 ("In these times of fiscal problems and downturns in state revenues, un-encumbered or un-used funds are taken from budgets and returned to the state's general funds. In essence, the nature of the RHC project almost insures that matching state funds may be come un-available.").

[49] *See* 47 C.F.R. § 54.702(c) ("[USAC] may not make policy, interpret unclear provisions of the statute or rules, or interpret the intent of Congress. Where the Act or the Commission's rules are unclear, or do not address a particular situation, [USAC] shall seek guidance from the Commission.").

policy guidance to USAC when necessary. The second is to rely more on self-certifications in the HIP – reflecting the usual practice with the RHC Program and other Universal Service Support Mechanisms.[50] Increased reliance on self-certification could be balanced by greater education and outreach efforts on the front end of the application process, and project audits on the back end after funds have been disbursed. HIEM believes a shift in emphasis to self-certification has great potential to streamline the HIP process and strongly urges the Commission to consider such a shift.

[50] *See, e.g.*, 47 C.F.R. §§ 54.209(a)(5)-(a)(8) (eligible telecommunications carrier annual self-certifications); § 54.313(b) (non-rural carrier self-certifications); § 54.314(b) (rural carrier self-certifications); § 54.410(b) (Low Income program eligible telecommunication carrier self-certifications); § 54.504(b)(2) (Schools & Libraries program Form 470 self-certifications); § 54.504(c)(1) (Schools & Libraries program Form 471 self-certifications); § 54.508(c) (Schools & Libraries program technology plan self-certification); § 54.603(b) (RHC Program Form 465 self-certifications); § 54.615(c) (RHC Program Form 466 self-certifications). Having USAC be responsible for approving HIP applications, as the Commission has proposed, may itself result in greater reliance on post-award self-certification.

III. CONCLUSION

HIEM again praises the Commission for the leadership and vision it has shown in the area of direct funding for rural health broadband infrastructure. HIEM respectfully urges the Commission to continue down the path it previously laid out in the RHCPP and to improve and broaden that path by reaffirming policies regarding network construction and excess capacity installation. These policies will benefit rural communities by creating shared rural broadband networks and encouraging the organizations that operate them to emerge and prosper. Such organizations are not only the missing link in realizing the full potential of the RHC Program, but they will be essential catalysts in their communities for the adoption of technologies that all recognize hold tremendous promise in providing increased health services and decreased health costs to our rural residents.

Respectfully submitted,

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September 23, 2010